Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TWELVE OAKS MEDICAL CENTER PO BOX 809053 DALLAS TX 75380	MFDR Tracking #:	M4-04-1502-01
Respondent Name and Box #: Argonaut Southwest Insurance Co. Box #: 17		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "While we feel our fees are fair and reasonable, the hospital will accept 75% of billed charges as a fair and reasonable amount. Please reprocess this claim for payment at that rate. I have enclosed five redacted EOBs, showing 'fair and reasonable' payments for diagnostic radiology. Some are for this hospital, and some are for our other facilities. The payments have been made at 84%, (3 at) 80% and 78% of the billed charges."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $426.75
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Paid per UCR utilizing the technical component of CPT code 73130."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/01/02	27, 940, 506	73130	$426.75	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 27 – "Technical Component"
   - 940 – "Re-evaluation – no additional payment recommended"
   - 506 – "Re-evaluated bill, payment adjusted"

   With additional payment advice: "CorVel has established that the technical component is fair and reasonable for the outpatient hospital diagnostic testing."

2. This dispute relates to outpatient diagnostic radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §134.401(b)(2)(D), effective August 1, 1997, 22 TexReg 6264, requires that "All bills for professional services rendered by a health care practitioner shall be submitted on form TWCC-67 [currently form DWC-67], the standard HCFA 1500 form."
5. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement"… The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "While we feel our fees are fair and reasonable, the hospital will accept 75% of billed charges as a fair and reasonable amount. Please reprocess this claim for payment at that rate. I have enclosed five redacted EOBs, showing 'fair and reasonable' payments for diagnostic radiology. Some are for this hospital, and some are for our other facilities. The payments have been made at 84%, (3 at) 80% and 78% of the billed charges." Review of the submitted documentation finds that the requestor did not submit evidence to support its assertion that the provider's billed fees are fair and reasonable. The requestor did not discuss or demonstrate how it determined that payment of 75% of the billed charges would result in a fair and reasonable reimbursement. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Additionally, the Division has determined that a methodology based on a percentage of billed charges does not, in itself, produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the *Acute Care Inpatient Hospital Fee Guideline* which states at 22 *Texas Register* 6276 (July 4, 1997) that "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources." Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of 75% of the billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, reimbursement in the amount of 75% of the provider's billed charges cannot be recommended. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.